STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	12/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

Michael J Madia, CEO 2/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.25 Pharmaceutical Services 42 CFR 482.41 Physical Environment Shell # 27QV11	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This Condition is not met as evidenced by: Based on observation, interviews, and document reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring Systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 risks an unsafe healthcare environment for patients, visitors, and staff. . Findings: . 1. The Governing Body failed to effectively manage the functioning of the hospital to protect patients from harm as evidenced by the IMMEDIATE JEOPARDY condition identified on 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. . 3. Failure to protect and promote each patient ' s rights. . 4. Failure to maintain the condition of the physical plant and the overall hospital environment of care. . Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. . Cross-Reference: Tags A0115, A0263, A0490, A0700 .	A 043	Amendment 2/1/2017: The CEO will issue weekly reports to the Governing Board related to the hospital's ongoing efforts toward compliance for all citations. Conference calls will be held as needed for dialogue. The target compliance is 90% for all standards cited. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: . Based on observation, interview, document review, and review of hospital policies and procedures, the hospital failed to protect and promote patient rights. . Failure to protect and promote each patient's rights risk the patient's loss of personal freedom, privacy, dignity, and psychological harm. . Findings: . 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. . 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. . 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. . 4. Failure to investigate patient complaints prior to closure of the complaint. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights. . Due to the scope and severity of deficiencies under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. . Cross Reference: Tags A0123, A0129, A0164, A0174 .	A 115	See A 0123, A 0129, A 0164, A 0174	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). . Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. . Findings: . 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." . 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Amendment 2/1/2017: The hospital's grievance policy, log for grievances, and letters that are to be mailed to patients have all been revised and will be presented at the weekly PI Committee on Thursday, February 9, 2017 for approval. From there, they will go the Medical Executive Committee on February 9, 2017 and Governing Board at its next meeting thereafter. Weekly data toward compliance in the new processes is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present an analysis of the grievance log and grievance responses to the monthly PI and quarterly MEC (next meeting is Feb 9, 2017) and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. . 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. . 4. On 12/15/2016 at 2:30 PM, Surveyor #3 Interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation. .	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: . Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. . Failure to allow patients the right torefuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. . Findings: . 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129	Amendment 2/1/2017: The hospital's skin check/contraband policy has been revised to remove the administrative discharge for patients who refuse the skin check process. Staff education has been conducted related to this change. Daily audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 129	Continued From page 8 coughing is no longer part of the process. . 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. . 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff . . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required. .	A 129		

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A 164	Continued From page 9 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "Restraints may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others after less-restrictive interventions are ineffective or ruled-out . . . " . The section titled "Patient Rights" read "Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. The type of technique or seclusion used must be the least restrictive	A 164	**A 0164 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17
A 164		A 164		

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." . 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. . 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. . 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. No documentation indicating that a less restrictive alternative had · been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found. .	A 164	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). . Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. . Findings: . 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." . 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. . 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." . 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: . a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: . --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. . --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. . --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. . --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours. .	A 174	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. . 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review. .	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: . Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	See A0273, A0286, A0309, A0490, A0700	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service andoperations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: . Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for Initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint and seclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273	Amendment 2/1/2017: The 2016 data for grievances, anticoagulants, restraints & seclusions, elopements, medication consultations, Pharmacy & Therapeutics indicators, and contracted services have been abstracted and analyzed and will go the PI Committee on or before Thursday, February 9, 2017 and then to the Medical Executive Committee on Thursday, February 9, 2017 and Governing Board thereafter. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and eppropriateness to the patient's individual needs. The Risk Manager end Chief Nursing Officer were responsible for data collection and analysis, end for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.	A 286	A 286 Corrective Actions 1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17
	This Standard is not met as evidenced by:			

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286	Amendment 2/1/2017: Going forward, the PI Committee will receive action plans for each Root Cause Analysis conducted along with a time frame for the completion of those action items. The PI Committee will add those items to minutes and receive follow-up at each of its meetings until all items are resolved. Action items will typically be resolved within 90 days, some sooner, depending on the urgency associated with that action item. The target compliance is 90% of all items completed with 90 days. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues	

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: . Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286 .	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: . Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405	Amendment 2/1/2017: CIWA protocols are currently being audited daily by the Nursing Director of CD Services. Analysis of the audits will go to the PI Committee at each weekly PI Committee starting Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Once several weeks of compliance is achieved, monitoring will become monthly with the same targets.	

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses. .	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings: . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verifiedby a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units,	A 490	See **Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: . Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought In with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initiallng of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient cere units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: e. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings. Amendment 2/1/2017: The pharmacy director is auditing 100% of home medications and will first report his findings to the weekly PI Committee on Wednesday, February 1, 2017, to the Medical Executive Committee on February 9, 2017 and to the Governing Board thereafter. Audits will continue until several weeks of compliance at or greater than 90% has been achieved and sustained. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.58 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a perlod of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493	Addendum 2/1/2017: Pharmacy has increased its hours of coverage in the evening hours. Overrides are being tracked daily and analyzed for time of day, type of drug, and reason for the override. The PI Director and Pharmacy Director will formally present their findings at the weekly PI Committee meeting beginning Wednesday, February 1, 2017. Pharmacy hours will continue to be adjusted as necessary to minimize the use of the override process. The facility will continue to evaluate hours needed by the pharmacy through recommendations by the contracted provider, number of over-rides due to lack of pharmacist to conduct the first dose review, and medication errors related to overrides.	

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units. .	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: . Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. . Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. . Findings: . 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	A **0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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	504011	A. BUILDING _____ B. WING _____	12/21/2016

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. . 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes. **A500 Amendment 2/18/2017** Cascade Behavioral Health was cited for pharmaceutical services not meeting the needs of its patients. The cumulative effect of these systemic problems/findings results in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. Immediate response included increased pharmacy hours by two (2) additional evening hours, seven (7) days per week. That staffing enhancement resulted in overrides being reduced to approximately 10 per day. Since then, the medical staff considered a night locker concept with a smaller inventory of medications but ultimately decided not to endorse this idea. Collectively, these systemic issues require additional time to implement process change, arrange additional pharmacy coverage, establish 24/7 coverage solution to review all orders, and eliminate nursing access and overrides.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. . 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. . 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation. .	A 500	**Proposed Interim Plan** Temporary night and weekend pharmacists to provide additional coverage will be in place by February 24, 2017. They will physically be present in the pharmacy to review and enter all new orders during their shift, just as the day-shift pharmacists currently do. The nurses' ability to override medications will be disabled permanently. All medication orders will be verified by a pharmacist prior to administration. **Responsible Person** Pharmacy Director (Pharmacist in Charge) **Proposed Long Term Plan** On or about April 1, 2017, the facility will transition pharmacist coverage to 24/7 through a combination of pharmacist on site and remote order entry. The Pharmacy Director, CEO and COO are evaluating options to obtain the necessary resources to establish this service within this expedited timeframe.	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700		

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: . Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726 .	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701	Amendment 2/1/2017: The pipes were occluded by temporary obstructions and have been assessed by an independent, professional plumber. The pipes have no on-going needs except routine cleaning and maintenance. To improve cleaning and maintenance, the hospital purchased distinct brushes to scour the drain pipes to remove hair and other debris. This cleaning will occur monthly and as needed and has been added to facility and housekeeping rounds. The hospital has switched to psych-safe paper towels that dissolve when wet to address drain clogging issues. **A701 Amendment 2/18/2017** We propose to cool, circulate, and dehumidify our outpatient/PHP rooms with two portable air conditioners designed for that purpose, one in each room where patient care is delivered. The rooms measure: 1) 19 feet by 19 feet (361 square feet) 2) 17 feet by 29 feet (493 square feet) Before the summer heat arrives, we will install two Honeywell model MM14CCS, or similar, units which are designed to cool 500 square feet. These quiet units provide 14,000 BTU cooling. They can be used to cool or use the fan and dehumidify the air. The units' venting kits would be installed for the air conditioner to operate properly.	

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms. .	A 701	Between now and the installation of these units, ventilation of these patient care rooms will be accomplished by the fan-forced heaters currently in use and oscillating fans. No policy is needed for staff to turn on the air conditioning. This will be based on a consensus of the group of patients and staff at the time as it relates to comfort.	
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availabilily of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings. .	2/10/17

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tippedapplicators with an expiration date of 2/2016. d. One box of sterile cotton-tippedapplicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of10/2016. f. One 14 french Foley urethral catheter with an expiration date of7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724	Amendment 2/1/2017: Daily audits are being conducted on each of the units. Unit champions are responsible for checking the ice machine logs to make sure the cleanings are happening at least weekly. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90% per unit. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 724	Continued From page 44 inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the Ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Dperations Director/designee will perform monthly inspections of all ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

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	504011	A. BUILDING _____ B. WING _____	12/21/2016

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A 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit. .	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	Amendment 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to food temperatures throughout the department. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. **A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
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A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749	Addendum 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision and will be presented to the PI Committee for approval on February 17, 2017. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to proper sanitation throughout the department. The COO/CNO will double check staff's compliance related to the use of chlorine solution, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 8, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Additionally, daily audits are being conducted throughout the hospital, observing housekeepers in their daily routines. Staff education is in process. The facilities director will be responsible for monitoring real-time compliance related to procedures when cleaning patient rooms. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

Cascade
Behavioral Health

February 18, 2017

Karen Roe - CMS

Re: Extension Request – Air Conditioning in Partial Hospital Program (PHP)

Ms. Roe:

I am writing to request an extension for the following findings related to ventilation during our December 12-21, 2016 survey:

- A701 – PHP rooms too hot (no a/c) & no ventilation
  - Two issues exist for this area: ventilation and temperature control. They are addressed separately below.

Ventilation	Temperature Control
During the winter, the department is ventilated by fan-forced heaters. In the spring, free-standing fans will be more than adequate to maintain proper ventilation.	During the winter, the department is heated by fan-forced heaters. In the spring, free-standing fans will be more than adequate to maintain a comfortable temperature as much of this building is below grade. Before temperatures reach 80 degrees, air conditioning will be installed. Anticipated installation date: May 1, 2017 or earlier if an early summer heat wave occurs.
Heaters & fans already in place.	It would be disruptive to the heating in this department to install air conditioning at present as it will be necessary to open an exhaust to the outside for the two portable air conditioners. We will make this installation when heating is no longer needed but certainly well in advance of the summer heat.

- Ventilation needs are already addressed through use of fan forced heat & oscillating fans.
- The revised date of installation of portable air conditioners is May 1, 2017, well in advance of the summer heat. Air conditioning will not be needed in that area until then.

If I can be of any further assistance, please do not hesitate to contact me at 206-248-4565 or john.beall@cascadebh.com

Sincerely,

Dr. John Beall, RN, DNP, NEA-BC

Chief Operating Officer & Chief Nursing Officer

Cascade Behavioral Health Hospital

CCN # S04011

Hospital License # HPSY.FS.60429197